NOTE: Before you return this form to your employer, you may wish to tape or staple the form so that health information is not visible. This will help keep your health information private.

aetna®

Maine Employee Enrollment/Change Form (51-100 employees)

Aetna Vision℠ Preferred plans, Aetna PPO plans and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna Whole Health HNOnly (Health Network Only) plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete Section G.** Please use only black ink to complete this form.

Group number
Aetna member ID number (if available)

Company name:

Effective date **Date of hire** **Benefit waiting period*** ☐ Class 1 ☐ Class 2 * Only required when your employer has 2 benefit waiting periods	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date: _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

☐ **COBRA** ☐ **State Continuation** for: ☐ Employee ☐ Dependent
Length of continuation: ☐ 18 months ☐ 36 months ☐ Other ____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. Employee information - *You must complete this section.*

Social Security number	Last name, first name, middle initial		Job title
Home address (must be the actual location for rates and network availability)	Apt. number	City, state	ZIP code
Mailing address - not needed if same as above (If this is completed, this is the address that will be used for all mailings and communications. May be a PO box.)		City, state	ZIP code
Work address		City, state	ZIP code

Home telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents, including spouse or domestic partner, enrolling for medical coverage

Salary (if enrolling for life or disability coverage) $ _____	☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

B. Coverage selection – *Please print clearly. (Top boxes for employer/Aetna-use only.)*

Control/Group number	**Suffix**	**Account**	**Plan number**	**Class code**

1. Medical ☐ Yes ☐ No *To enroll, check one and enter the plan option elected following the plan type below.*

☐ **ME Aetna Whole Health HNOnly** – Plan option: _____
☐ **ME Aetna Whole Health HNOnly HSA Compatible** – Plan option: _____
☐ **ME Open Choice® PPO** – Plan option: _____
☐ **ME Open Choice® PPO HSA Compatible** – Plan option: _____
☐ **ME Indemnity** (only available if PPO networks are not available) – Plan option: _____

B. Coverage selection *(Continued)*

Control/Group number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, enter the plan number and name below.*

Non-voluntary plans – Plan number: _____ Plan name: _____

Voluntary plans – Plan number: _____ Plan name: _____

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Control/Group number	Suffix	Account	Plan number

3. Vision

Aetna Vision℠ Preferred ☐ Yes ☐ No

C. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.***

NOTE FOR MEDICAL COVERAGE: While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

1 ☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)		Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
Primary care physician (PCP) provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

2 ☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner**	Sex (M/F)	Social Security number
Birth date (MM/DD/YYYY) / /	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

3 ☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

4 ☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

Continued on next page

C. Individuals covered *(Continued)*

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial)	☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

6	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial)	☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

D. Dependent information

List any dependent in Section **C** with a different last name or living at another address.

Name	Address

E. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

F. Medicare information

Name of person	Medicare Part A	Medicare Part B	Medicare Part D	Over age 65	Disability	End-stage renal disease effective date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

G. Declining coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer; however, I am declining the coverage I checked below:

☐ Employee: ☐ Medical ☐ Dental ☐ Vision

☐ Spouse / domestic partner: ☐ Medical ☐ Dental ☐ Vision

☐ Child(ren): ☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse / domestic partner group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE / Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Another group plan provided by my employer
- ☐ Do not want
- ☐ Other _____

I certify I have been given the right to apply for this coverage; however, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s). | ***Date (Month/Day/Year)***

☐ I am declining coverage. **Employee signature:** X

Please PRINT employee name:

Conditions of enrollment

On behalf of myself and the dependents listed, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna Whole Health HNOnly plans: Aetna Health Inc.
   - Aetna PPO plans and Indemnity plans: Aetna Life Insurance Company
   - Aetna Vision℠ Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates
   - Dental and other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage until Aetna has approved both my employee enrollment form and the employer applications.
3. I authorize Aetna Health Inc. and / or Aetna Life Insurance Company, its authorized employees, agents, consultants and designees, health care providers, third party payers, accreditation organizations and utilization review agencies, to exchange health care, medical, mental health, substance abuse, AIDS, and related insurance information, any of which relates to me, for purposes of claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement / management / assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. **This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.** I give authorization for myself and any eligible family members listed on this application for whom I am authorized to do so. I understand that I may receive a copy of this form. I further understand that this authorization will be effective for thirty (30) months, unless I give written notice to Aetna Health Inc. that I want to revoke this authorization. I understand that my failure to agree to this authorization, or my revocation of this authorization, may impair the ability of Aetna Health Inc. and / or Aetna Life Insurance Company to evaluate or process an application or claim and may be a basis for denying an application or claim for benefits. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the plans described above.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I authorize Aetna's right of subrogation as provided in 24-A M.R.S.A.§2836.

To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I have read and understand this form in its entirety and agree to the conditions of enrollment and misrepresentation on this Employee Enrollment / Change Form.

I understand that in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my eligibility and my dependents' eligibility may be affected.

I am employed by the employer shown on **page 1**. I am working full time or at least 25 hours or more a week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

Misrepresentation: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

If you wish to receive documents online, please visit your secure member account at aetna.com/individuals-families/aetna-navigator.html

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependent(s). ***Employee signature (required)***	***Employee email***	***Date (Month/Day/Year)***

Company Name:
Employee Name:

H. Health questionnaire must be completed for all individuals enrolling for coverage.

Health history for you and your dependents. ***The following information is confidential and will not be seen by or given to your employer.***
You or your dependents must answer ALL of the questions. Incomplete enrollment forms may delay the date your coverage starts.

1. Within the last **five** years, has anyone applying for coverage consulted with or received treatment from a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ Diabetes
b. ☐ Infertility
c. ☐ Endocrine/ metabolic
d. ☐ Pancreas
e. ☐ Liver / hepatitis
f. ☐ Immune system
g. ☐ Blood disorder
h. ☐ Hemophilia
i. ☐ Epilepsy / seizure
j. ☐ Heart
k. ☐ Paralysis / paresis
l. ☐ Tumor / cyst / growth
m ☐ Systemic or discoid lupus
n. ☐ Lung or respiratory
o. ☐ Alcohol or drug use
p. ☐ Kidney / bladder / urinary
q. ☐ Circulatory / vascular
r. ☐ Digestive / stomach / intestinal
s. ☐ Central nervous system
t. ☐ Connective tissue disorder
u. ☐ Pituitary / adrenal / growth disorder
v. ☐ Birth defects / congenital abnormalities
w. ☐ Arthritis / bone / joint / muscle / prosthetic device
x. ☐ Mental / nervous / emotional / eating disorder
y. ☐ Stroke / brain / neurological
z. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
aa. ☐ Advised to have ☐ Tests, ☐ Surgery, ☐ Hospitalization or is ☐ treatment needed, or ☐ course of treatment not yet determined
bb. ☐ Cancer: Type:_____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
cc. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
dd. ☐ Other _____

2.	Has any person listed on this enrollment form tested positive for exposure to the human immunodeficiency virus (HIV) or been diagnosed with acquired immune deficiency syndrome (AIDS) caused by HIV or other sickness or condition derived from this infection? Or has any person listed on this enrollment form been diagnosed with AIDS-related complex (ARC)?	☐ Yes ☐ No
3.	Is anyone currently pregnant? Due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple births expected (Number _____) ☐ Complications: ☐ Past or ☐ Present	☐ Yes ☐ No
4.	Has anyone applying for coverage had more than $5,000 in medical expenses in the past 24 months?	☐ Yes ☐ No
5.	Has anyone applying for coverage been prescribed medications in the past 12 months?	☐ Yes ☐ No
6.	Does anyone applying for coverage have a known condition that requires ongoing treatment?	☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION H, YOU MUST COMPLETE SECTIONS I and J.

I. Health questionnaire – Details for "Yes" answers in Section H.

List all individuals enrolling for coverage. Name	Age	Height	Weight	Cigarette smoker	Currently taking prescription medication(s)
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

J. Provide details below to any boxes checked above. (If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)

Ques. No.	Name	Condition / diagnosis / treatment	Date of onset	Date treatment ended	Names of prescription medication	Dosage	Still taking medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Employee signature (required)	*Date (Month/Day/Year)*